

PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services **or** the Primary Medical Provider (PMP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted to Medicaid's System Support Unit within 45 days of the date of service. Overrides will not be considered unless the PMP has been **contacted and refused** to authorize treatment. Attach a "clean claim" with any supporting documentation to this form and mail to System Support at the address below. System Support will process your request within 30 days of receipt. If your request is approved, the corrected claim will be sent to EDS and will be processed. If your request is denied, System Support will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.state.al.us.

**Mail To: Alabama Medicaid Agency
System Support
501 Dexter Avenue
Montgomery, Alabama 36103**

Recipient Name: _____ Medicaid Number: _____

Date(s) of Service _____

Name of PMP: _____

Name of person contacted at PMP's office: _____ Date contacted: _____

Reason PMP stated he would not authorized treatment: _____

I am requesting an override due to:

☐ Recipient assigned incorrectly to PMP. Please explain: _____

☐ This recipient has moved.

☐ Unable to contact PMP. Please explain: _____

☐ Other. Please explain: _____

Provider Name: _____ Provider Number: _____

Provider Contact: _____ Telephone: (____) _____ Fax: (____) _____